		NTSB ID: SEA08IA080		Aircraft Registration Number: N651BR	
		Occurrence Date: 02/13/2008		Most Critical Injury: None	
		Occurrence Type: Incident		Investigated By: NTSB	
Location/Time					
Nearest City/Place Hilo	State HI	Zip Code 96720	Local Time 0945	Time Zone HST	
Airport Proximity: Off Airport/Airstrip		Distance From Landing Facility: 26			
Aircraft Information Summary					
Aircraft Manufacturer Bombardier, Inc.		Model/Series CL-600/2B19		Type of Aircraft Airplane	
Revenue Sightseeing Flight: No			Air Medical Transport Flight: No		
Narrative					
<p>Brief narrative statement of facts, conditions and circumstances pertinent to the accident/incident:</p> <p>HISTORY OF FLIGHT</p> <p>At 0916 on February 13, 2008, a Bombardier CL-600-2B19, N651BR, operated by Mesa Airlines as Go! Flight 1002 departed Honolulu International Airport (HNL), Honolulu, Hawaii, on a regularly scheduled domestic, passenger flight using the call sign Air Shuttle Flight 1002 (ASH1002). About halfway through the flight, the pilots of ASH1002 stopped responding to air traffic control communications. While out of radio communications, the flight passed over its destination airport, General Lyman Field (ITO), Hilo, Hawaii, at cruise altitude. After traveling 26 nautical miles beyond ITO on a constant heading, the flight crew resumed radio communications with air traffic control and returned to land at ITO. The airplane was not damaged and the captain, first officer, flight attendant, and 40 passengers were not injured during the event. The flight was conducted in accordance with 14 Code of Federal Regulations (CFR) Part 121. An instrument flight rules (IFR) flight plan was on file and activated during the flight. The first officer was assigned the role of the flying pilot.</p> <p>The flight crew's communications with air traffic control during departure from Honolulu had been routine. About 0930, the captain had contacted Honolulu Control Facility (HCF) and informed the facility that ASH1002 was climbing through 11,700 feet to its cruise altitude, Flight Level 210. HCF acknowledged this transmission and cleared the flight to proceed direct to the PARIS intersection, near the big island of Hawaii. The captain acknowledged the clearance but the flight did not change course. About 0933, HCF again cleared ASH1002 direct to the PARIS intersection. The captain acknowledged the instruction a second time, and the flight's track turned toward PARIS. Both pilots later stated that soon after they received this clearance they inadvertently fell asleep in the cockpit. The captain stated, "Working as hard as we had, we tend to relax." He further stated, "We had gotten back on schedule, it was comfortable in cockpit, the pressure was behind us. The warm Hawaiian sun was blaring in as we went eastbound. I just kind of closed my eyes for a minute, enjoying the sunshine, and dozed off." The first officer said he entered a sleep-like state from which he could "hear what was going on, but could not comprehend or make it click."</p> <p>At 0940, as the flight was crossing the island of Maui. HCF instructed ASH1002 to change radio frequencies, but the flight crew did not respond. For the next 18 minutes, HCF attempted to contact ASH1002, but received no replies. About 0951, ASH1002 reached the PARIS intersection and turned southeast toward the Hilo VOR. The HCF controller who was handling the flight asked another HCF controller to contact ASH1002 on a different radio frequency. The other controller made the attempt, but received no reply. At 0955, ASH1002 crossed the Hilo VOR. It continued southeast at Flight Level 210, crossed the northeast coast of Hawaii and flew out over the open ocean. HCF asked another Go! flight crew to try to contact ASH1002 on a company radio frequency. The flight crew made the attempt, but received no reply. In addition, a Continental Airlines flight attempted to contact ASH1002 on an emergency frequency, but was also unsuccessful.</p>					
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About this time, the first officer awoke. Realizing the airplane was off course, he noted that 4,500 pounds of fuel remained. He estimated that this amount would last an hour and a half. Next, the first officer woke the captain and told him air traffic control was attempting to contact the flight. About 0958, the captain contacted HCF, stating, "[unintelligible] HCF ten zero two." HCF asked the captain if the flight crew was experiencing an emergency situation, and the captain replied, "No, we must have missed a handoff or missed a call or something." HCF then issued vectors for ASH1002 to return to ITO, and the flight crew complied. The flight arrived at 1015.

As ASH1002 arrived at ITO, air traffic controllers directed the captain to contact them by telephone. After the airplane was parked at the gate, the captain instructed the first officer to prepare the airplane for its next flight while he disembarked and called the FAA. The captain told FAA personnel by telephone that ASH1002 had lost radio communications because the flight crew had selected an incorrect radio frequency. FAA personnel informed the captain that they intended to report the incident to Mesa Airlines.

After his telephone conversation with the FAA, the captain returned to the airplane and had a discussion with the first officer about whether they should operate the next flight. The pilots agreed that it would be safe for them to do so because they were feeling very alert as a result of the incident. According to company records, they departed ITO for HNL on the incident airplane at 1028, using the call sign ASH1044. During the flight to HNL, the pilots discussed the incident further and they decided to remove themselves from duty upon arrival. ASH1044 arrived at HNL at 1118.

After parking at the gate, the captain arranged for a reserve crew to operate the next flight he had been assigned to fly with the first officer. Next, the captain called the airlines scheduling office to inform the company that both he and the first officer were removing themselves from duty for the rest of the day. The captain's telephone call was transferred to a chief pilot who requested an explanation for the flight crew's decision. The captain declined to provide an explanation on the telephone. A few hours later, however, he submitted a written report to Mesa Airlines explaining that he and the first officer had fallen asleep on ASH1002 during the cruise phase of flight.

PERSONNEL INFORMATION**Flight Crew****Captain**

The captain, age 53, held an airline transport pilot (ATP) certificate for airplane multiengine land, and commercial privileges for airplane single-engine land. He possessed type ratings in the following airplanes: BA-3100, BE-300, BE-1900, CL-65, DHC-8, and SA-227. His pilot certificate carried the following limitation, "BE-300, BE-1900, SECOND-IN-COMMAND REQUIRED."

Company records indicated that the captain had completed his last recurrent training on July 19, 2007, his last line check on December 5, 2007, and his last proficiency check on January 4, 2008.

The captain had worked as an airline pilot for over 20 years. Air Midwest hired him as a pilot on October 7, 1987. Mesa Airlines acquired Air Midwest in 1991, and the captain became an employee of Mesa Airlines on September 3, 1997. At that time, he was a captain on the Beech 1900D. On September 16, 1997, he transitioned to the position of captain on the de Havilland DHC-8, and on July 23, 1998, he transitioned to the position of captain on the CL-65.

The captain's statements and company records indicated that he had between 20,000 and 25,000 hours of flight experience, including 8,000 hours as pilot-in-command in the CL-65. The captain reported 830 flight hours in the last 12 months, 415 hours in the last 6 months, 207 hours in the last 90

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days, 76 hours in January 2008, and 38 hours during the period February 1-12, 2008.

The captain resided in Kennett, Missouri and had been based in the company's Nashville, Tennessee domicile. At the time of the incident, he was temporarily assigned to Mesa's Kahului, Hawaii domicile. This temporary assignment had begun January 13, 2008 and was originally scheduled to end February 9, 2008. Near the end of this period, however, the temporary assignment was extended for an additional 28 days.

The captain's activities in the three days preceding the incident were as follows:

On Sunday, February 10, 2008, he reported for duty at OGG at 0740, flew 4 legs and went off duty at OGG at 1445. He reported going to sleep between 2030 and 2100, and described his quality of sleep as "probably good."

On Monday, February 11, 2008, the captain awoke at 0400. He reported for duty at OGG at 0540, and was paired with the incident first officer. He and the first officer flew 8 flights together. He went off duty at OGG at 1445. He could not recall his activities the rest of the day, but reported going to sleep between 2030 and 2100. He described his quality of sleep as "probably good."

On Tuesday, February 12, 2008, the captain awoke at 0400. He bought breakfast at a fast food restaurant and reported for duty at OGG at 0540. The captain was paired with the incident first officer. Their first flight was slightly delayed because the flight attendant arrived late. The captain and first officer operated 8 flights together and the captain went off duty at OGG at 1447. The captain returned to his hotel and spent two hours trying to obtain a new rental car reservation, as his rental car agreement was about to expire. He was unsuccessful, so he then ran some errands, bought dinner at a fast food restaurant, and returned his car about 1930. He used his hotel's shuttle service to return to his room, and arranged for the incident first officer to pick him up and drive him to work the next day. He reported going to bed between 2000 and 2100, and he described his quality of sleep as "pretty good."


On Wednesday, February 13, 2008, the captain awoke at 0400. The incident first officer arrived later than he expected, so the captain was unable to buy breakfast on the way to the airport. The captain reported for duty at OGG at 0540. Because of a flight attendant scheduling error, the crews first flight departed 30 minutes late. The captain shared a package of cookies with the first officer on the airplane, and flight crew was back on schedule as they departed HNL at 0916 on the incident flight.

Captain's Prior In-Flight Napping Behavior

The captain stated that he had never before inadvertently fallen asleep during a flight, but he had intentionally napped in the cockpit during previous flights. He said he had intentionally napped in flight about once per week during his temporary assignment in Hawaii, and that his naps normally lasted about 20 minutes. Furthermore, he stated that he had napped more often than once per week prior to beginning his temporary assignment in Hawaii. A Mesa first officer who had flown with the captain in the continental U.S. confirmed that the captain had napped on flights they had operated together. Mesas senior director of flight operations said that, before the incident, he had been unaware of the captain's in-flight naps.

First Officer

The first officer, age 23, held a commercial pilot certificate for airplane single-engine land, airplane multiengine land, and instrument airplane. He possessed type ratings for G-1159 and CL-65 airplanes. His type rating on the CL-65 was for "second-in-command privileges only" and it contained a limitation stating that he could only perform circling approaches in visual

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meteorological conditions (VMC).

Mesa Airlines had hired the first officer on May 8, 2007. He had completed initial ground training for the CL-65 on June 10, 2007, initial flight training on July 14, 2007, and initial operating experience (IOE) on September 1, 2007.

According to company records, the first officer had 1,250 hours of flight experience, including 500 hours in the CL-65. He had accumulated 240 hours in the last 90 days, 80 hours in the preceding 30 days, and 38 hours during the period February 1-12, 2008.

The first officer was assigned to the airlines Kahului domicile, and he resided nearby in Kahului.

The first officer's activities in the three days preceding the incident were as follows:

On Sunday, February 10, 2008, the first officer was off duty and he visited with friends on the big island of Hawaii. He reported that he returned to Maui about 1430 and went to sleep by 2200. He could not recall his quality of sleep.

On Monday, February 11, 2008, the first officer reported waking between 0450 and 0500. He reported for duty at OGG at 0540 and was paired with the incident captain. After completing 8 legs with the captain, the first officer went off duty at OGG at 1445. He reported going to sleep by 2200, and could not recall his quality of sleep.

On Tuesday, February 12, 2008, the first officer awoke between 0450 and 0500. He reported for duty at OGG at 0540 and was again paired with the incident captain. He completed 8 legs and went off duty at 1447. After going off duty, he engaged in outdoor sports and had dinner about 1730. He reported going to sleep at 2130, and described his quality of sleep as "good."

On Wednesday, February 13, 2008, the first officer awoke between 0450 and 0500. He had a pastry for breakfast. He reported for duty at OGG at 0540 and was again paired with the incident captain.

First Officer's Previous In-Flight Sleeping Behavior


The first officer stated that he had never fallen asleep during a flight before.

Operational Stressors Reported by the Flight Crew

The flight crew reported several operational stressors in the days before the incident. The pilots reported (and company managers confirmed) that the airplane they had operated on February 11 had a partially functioning flight management system. This forced the pilots to navigate using VOR radials rather than flying directly between navigational waypoints. As a result, they were unable to accept some typically ATC clearances. They reported that this caused them to experience increased workload.

On February 12, the flight crew was again assigned the airplane with the partially functioning flight management system. After a few flights, however, they were assigned a different airplane with a fully functioning flight management system. Also on the morning of February 12, the flight attendant assigned to work their first flight arrived late, placing them slightly behind schedule. The flight crew had to rush to make up the time on subsequent flights.

On February 13, the crew learned that the flight attendant assigned to their first flight had been scheduled in error. The flight crew made arrangements for a replacement flight attendant, but this delayed their departure by 30 minutes. The flight crew had to rush during their first three flights of the day to make up the delay.

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MEDICAL AND PATHOLOGICAL INFORMATION

Captain

The captain's most recent FAA first-class medical certificate was issued on December 18, 2007, and it bore the limitation "must wear corrective lenses while exercising the privileges of this certificate."

The captain described his health as "fair." He stated that he was prone to respiratory illnesses, but had not experienced any the week before the incident. He reported high blood pressure and took a combination prescription medication (trandolapril/verapamil 4/240) to control it. He stated that he had not taken any medications, prescription or nonprescription, that might have affected his performance.

The captain was a regular smoker, and reported smoking about 25 cigarettes per day. He reported smoking his last cigarette before departure on his first flight of the day, at 0655. He stated that he carried nicotine gum when he was working, but could not recall whether he had used it on the morning of the incident. He stated that he drank alcohol, but had not consumed any in the 24 hours before the incident.

The captain said he had been feeling "burned out" in recent months. He attributed this to his working conditions, less time off, and frequent amendments to his schedule. He said that he had encountered these challenges before, but had recently been finding it more difficult to cope with them. He stated that he had applied for the temporary assignment in Hawaii in search of some relief, but had found the work in Hawaii no easier because he had to fly 8 legs per day with few breaks. This minimized his ability to obtain coffee, eat, and smoke cigarettes.

The captain said that he snored loudly at night, and that he had raised the issue with his personal physician in December 2007. He stated that his physician had told him to lose weight, eat less salt, and relax. He stated that, during his stay in Hawaii he had lost 15 pounds through exercise and was "sleeping better."

The captain said he had been having difficulty adjusting to day to day life in Hawaii, and that he would have preferred to return to the mainland rather than have his temporary duty assignment extended.

Captains Post-Incident Sleep Evaluation

After the incident, the captain underwent an evaluation by a sleep medicine specialist and was diagnosed with severe obstructive sleep apnea, a condition associated with reduced sleep quality, daytime fatigue, and, in severe cases, cognitive dysfunction. The evaluating physician wrote that the captain's condition provided "an etiology for significant fatigue".

First Officer

The first officer's most recent FAA first class medical certificate was issued on February 2, 2007, and contained no limitations.

The first officer described his health as "good," and he said he felt well on the morning of the incident. He stated that he did not normally take prescription medication, and that he had not taken any medication, prescription or nonprescription, in the 72 hours before the incident.

The first officer stated that he did not use tobacco products. He reported that he did drink alcohol, and last consumed some about 1700 the day before the incident, when he drank one beer.

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The first officer said he was not experiencing any stress related to his personal life on the morning of the incident, nor had he experienced any recent changes in his health or personal life. He stated that, in the past year, he had experienced a positive change in his finances as a result of his employment with Mesa Airlines.

The Flight Crews Post-Incident Toxicological Testing

On the morning of February 14, 2008, Mesa Airlines senior director of flight operations asked the captain and first officer to provide a urine specimen that could be tested for drug testing and they complied. These tests yielded no evidence of drug use. The senior director told investigators he did not request urine specimens until the day after the incident because he did not receive information describing the nature of the incident until the evening of February 13, 2008.

SURVIVAL FACTORS

An NTSB Survival Factors Specialist interviewed the incident flight attendant on March 27, 2008. During an interview the flight attendant stated that she had flown 4 legs with the flight crew, and that neither of them appeared tired. She described the captain's preflight as being "very short", and was concerned that on the first of the 4 legs that the flight crew did not provide a sterile cockpit signal ("ding"); she also revealed that she did not receive the sterile cockpit signal on the second leg. She did not recall and couldnt say whether she had received the sterile cockpit signal on the 3rd and 4th legs of the trip.

The flight attendant reported that the incident flight was between 37 to 40 minutes in length, and that while she was wearing a watch she did not recall if she looked at it after take-off on the incident flight. She indicated that she did not notice anything unusual about the flight and did not sense that it was longer than usual, nor did she feel that there was anything "unsafe." She reported that she is normally aware of the flights position and how much longer the flight will take by the flight crew's announcement that they are descending.


When the specialist asked the flight attendant if she is normally aware of the terrain that the airplane is flying over, the flight attendant stated that she may notice their location during the middle of the flight because she is in the cabin and can see out of passenger windows. When she is on her jump seat she is not able to see the terrain because the only window available is on the service door.


When asked when she would contact the flight crew the flight attendant responded that she did not normally contact the flight deck crew during a flight, but she would if it was an unusually long flight or if she had a passenger problem or a safety-related issue.


When questioned by the specialist about her training for an "incapacitated pilot," the flight attendant replied that if she was contacted by the other pilot and admitted to the flight deck she was trained on how to pull out the pilot's seat. The flight attendant revealed that she had no access to the flight deck unless admitted by a pilot.


She was asked what she would do if she thought the flight was going on longer than she thought was normal and had not heard from the pilots. She said that she would use the interphone to contact the flight crew. If the interphone did not work, she would use her cell phone to call someone.

The flight attendant described the company's Crew Resource Management (CRM) training as "pretty thorough". She indicated that the training included information about crew introductions, procedures for emergencies, and safety issues with the crew. She was asked about contacting the cockpit during sterile cockpit and she said sterile cockpit was a critical time of flight and she would not contact the flight crew during that time unless it was an emergency, such as a passenger

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<p>problem, fire, or other safety-related problem.</p> <p>ORGANIZATIONAL AND MANAGEMENT INFORMATION</p> <p>Company History</p> <p>On June 9, 2006, Mesa Airlines launched Go! Airlines as a wholly-owned subsidiary providing scheduled service between Honolulu International Airport and airports in Hilo, Kahului, Kona, and Lihue, Hawaii. According to Mesas senior director of operations, Go!s initial fleet consisted of two Canadair Regional Jets. Four months later, Mesa added three additional regional jets to the fleet. Go! had maintained a fleet of five regional jets and a workforce of about 60 pilots from then until the day of the incident.</p>			
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Landing Facility/Approach Information						
Airport Name Hilo International Airport		Airport ID: PHTO	Airport Elevation 13 Ft. MSL	Runway Used N/A	Runway Length	Runway Width
Runway Surface Type:						
Runway Surface Condition:						
Approach/Arrival Flown: Visual						
VFR Approach/Landing: Full Stop; Traffic Pattern						
Aircraft Information						
Aircraft Manufacturer Bombardier, Inc.		Model/Series CL-600/2B19		Serial Number 7426		
Airworthiness Certificate(s): Transport						
Landing Gear Type: Retractable - Tricycle						
Amateur Built Acft? No		Number of Seats: 54		Certified Max Gross Wt. LBS	Number of Engines: 2	
Engine Type: Turbo Fan		Engine Manufacturer: General Electric		Model/Series: CF34-3B1		Rated Power: 9244 LBS
- Aircraft Inspection Information						
Type of Last Inspection Continuous Airworthiness		Date of Last Inspection 02/2008		Time Since Last Inspection 3 Hours		Airframe Total Time 16431 Hours
- Emergency Locator Transmitter (ELT) Information						
ELT Installed?/Type Yes /		ELT Operated? No		ELT Aided in Locating Accident Site? No		
Owner/Operator Information						
Registered Aircraft Owner Wachovia Bank NA Trustee		Street Address				
		City Charlotte		State NC	Zip Code 28288	
Operator of Aircraft Mesa Airlines		Street Address				
		City Phoenix		State AZ	Zip Code 85008	
Operator Does Business As: GO				Operator Designator Code: MASA		
- Type of U.S. Certificate(s) Held:						
Air Carrier Operating Certificate(s): Flag Carrier/Domestic						
Operating Certificate:			Operator Certificate:			
Regulation Flight Conducted Under: Part 121: Air Carrier						
Type of Flight Operation Conducted: Scheduled; Domestic; Passenger Only						
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First Pilot Information					
Name		City		State	Date of Birth
On File		On File		On File	On File
					Age
					53
Sex: M	Seat Occupied: Left	Occupational Pilot? Yes		Certificate Number: On File	
Certificate(s): Airline Transport; Commercial					
Airplane Rating(s): Multi-engine Land; Single-engine Land					
Rotorcraft/Glider/LTA: None					
Instrument Rating(s): Airplane					
Instructor Rating(s): None					
Current Biennial Flight Review? 01/2007					
Medical Cert.: Class 1		Medical Cert. Status: With Waivers/Limitations		Date of Last Medical Exam: 12/2007	
- Flight Time Matrix	All A/C	This Make and Model	Airplane Single Engine	Airplane Multi-Engine	Night
Total Time	25000	8000			
Pilot In Command(PIC)		8000			
Instructor					
Instruction Received					
Last 90 Days	207	207			
Last 30 Days	76	76			
Last 24 Hours	6	6			
Seatbelt Used? Yes		Shoulder Harness Used? Yes		Toxicology Performed? No	
				Second Pilot? Yes	
Flight Plan/Itinerary					
Type of Flight Plan Filed: IFR					
Departure Point	State			Airport Identifier	Departure Time
Honolulu	HI			HNL	0916
					Time Zone
					HST
Destination	State			Airport Identifier	
Same as Accident/Incident Location				HTO	
Type of Clearance:					
Type of Airspace:					
Weather Information					
Source of Wx Information:					
Automated Report					


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Weather Information					
WOF ID	Observation Time	Time Zone	WOF Elevation	WOF Distance From Accident Site	Direction From Accident Site
HTO	0953	HST	38 Ft. MSL	NM	Deg. Mag.
Sky/Lowest Cloud Condition: Clear				Ft. AGL	Condition of Light: Day
Lowest Ceiling: None			Ft. AGL	Visibility: 10 SM	Altimeter: 30.13 "Hg
Temperature: 22 °C	Dew Point: 16 °C	Weather Conditions at Accident Site: Visual Conditions			
Wind Direction: 230	Wind Speed: 3	Wind Gusts:			
Visibility (RVR): Ft.	Visibility (RVV) SM				
Precip and/or Obscuration: No Obscuration; No Precipitation					

Accident Information					
Aircraft Damage: None		Aircraft Fire: None		Aircraft Explosion: None	

- Injury Summary Matrix	Fatal	Serious	Minor	None	TOTAL	
First Pilot				1	1	
Second Pilot				1	1	
Student Pilot						
Flight Instructor						
Check Pilot						
Flight Engineer						
Cabin Attendants				1	1	
Other Crew						
Passengers				40	40	
- TOTAL ABOARD -				43	43	
Other Ground						
- GRAND TOTAL -				43	43	

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Administrative Information		
Investigator-In-Charge (IIC) Thomas Little		
Additional Persons Participating in This Accident/Incident Investigation: Warren Hann Federal Aviation Administration Honolulu, HI Dr. William Bramble National Transportation Safety Board Washington, DC Nora Marshall National Transportation Safety Board Washington, DC Dr. Mitch Garber National Transportation Safety Board Atlanta, GA		
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